

Cultural meaning in health communication

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Abstract

Health concepts and issues are deeply embedded in culture. Communication about health needs to take this into account, particularly in a multicultural discourse where discourse members have different cultural backgrounds. Words and their meanings are not fixed as often displayed in dictionaries. Apart from cognitive meaning, there are also cultural meanings which are not revealed in lexical definition. Words such as hygiene, disease, mental, drinking, pollution etc. can cause miscommunication in a multicultural discourse. However, communication barriers do not just occur at word levels. Communicative problems associated with speech acts, presupposition, use of metaphors etc. are widespread but not easily recognised. In regards to health, it is important to examine the specific role of culture as a factor in enhancing the effectiveness of communication in a multicultural discourse, particularly in relation to the youth health and well being.

Keywords: culture, health care, communication, language, diversity, health literacy

Introduction

Culture is widely accepted as a factor associated with health concepts and behaviour but its role in limiting communication in health care practice is discussed. Communication about health needs to consider this factor, particularly in a multicultural discourse where discourse members have different cultural backgrounds. Words and their meanings are not fixed as often displayed in dictionaries. Apart from cognitive meaning, there are also cultural meanings which are not revealed in lexical definition. Words such as hygiene, disease, mental, drinking, pollution etc. can cause miscommunication in a multicultural discourse. However, communication barriers do not just occur at word levels. Communicative problems associated with speech acts, presupposition, use of metaphors etc. are widespread but not easily recognised. The discussion in this paper will examine linguistic and cultural factors in health communication with a focus on intercultural discourse and implications for migrants and youths.

Understanding culture

Culture has been defined as the shared products of the society, including the ideas, norms, and material objects that describe how people handle daily tasks and make sense of their experiences. *Social scientists generally agree that culture is learned, shared, transmitted intergenerationally, and reflected in a group's values, beliefs, norms, practices, patterns of communication, familial roles, and other social regularities.* Culture is also dynamic and adaptive (Carolyn 2001).

The culture of an individual has a profound effect on the perspective from which they deal with health and illness. Culture has influenced peoples' "convictions, attitudes, types of knowledge, and values; modes of behaviour, habits and customs; language and tradition.

(Janelle & Celeste Mulry 2006)

The relationship between culture, communication and health care has been a very complex theme which permeates various academic disciplines such as health science, sociology, psychology, bioethics, and linguistics. This complex relationship emerges strongly in intercultural discourse where patients, their family and health workers reveal their cultural attitudes and behaviours and problems which may arise due to cultural conflicts. The following two cases are examples of such a cultural conflict:

Case 1: A mother brings her 18-month-old daughter to a clinic for a routine physical examination. The child has had no immunisations. Her mother says that they believe in naturopathic medicine and prefer not to immunise their children.

Case 2: A 3-year-old child is brought to a clinic with a fever and stiff neck. Doctors are quite certain the child has meningitis. When the doctors discuss the need for a spinal tap and antibiotic treatment, the parents refuse permission, saying, "We'd prefer to take him home and have our minister pray over him." (University of Washington 1998).

According to Margareth and Iraj (2006), the cultural characteristics of any given group may be directly or indirectly associated with health-related priorities, decisions, behaviours, and/or with acceptance and adoption of health education and health communication programs and messages. Thus, it is important for health workers to have some intercultural awareness or cultural competence to deal with health in a multicultural discourse. Cultural competence is not confined to one's own culture:

Cultural competence has been defined as 'the ability to identify and challenge one's cultural assumptions ... the ability to see the world through different cultural lenses ... to analyse and respond to the 'cultural scenes' and 'social dramas' in ways that are culturally and psychologically meaningful ... for client and professional alike ... and the ability to turn such thinking into praxis ... providing meaningful, satisfying and competent care'

(Eisenbruch & Dowton 2000)

The following discussion will examine the multidimensional aspects of linguistic communication and intercultural communication in relation to health care.

Framework for health communication: the message sent is the message received

McGuire (1989) defines a communication framework consisting of five types of factors – source, message, channel, receiver, and destination – which are known to influence communication effectiveness. It is corresponding directly to Lasswell's (1948) well-known description of communication as *who, says what, through which channel, to whom, and with what effect*. Therefore, at the most basic level, operational decisions in planning and carrying out communications, choosing message strategies, and determining optimal settings or channels for delivery of the communication is very important (Kreuter & McClure 2004).

Broadly speaking, communication is the process in which a message is sent from a sender to a receiver. It is expected that the message remains the same when it is received. Otherwise miscommunication occurs. For instance, when a doctor tells a

patient to take one tablet a day, and if the patient does not fully understand the doctor's message, it can affect the patient's health problem and in some cases, the result can be catastrophic.

Diversity and culture should be taken into account at each of these decision points when developing health programs that target culturally diverse population (Kreuter & McClure 2004). Miscommunication or communication failure in the health discourse tends to happen to migrants whose knowledge of English is very limited. When doctors orally instruct patients to use medicine, the instruction should be fully understood. Translators and interpreters are helpful in this kind of transaction. However, in many cases, particularly in remote areas, where interpreters are not available, linguistic failure leads to health failure.

Linguistic ambiguity

A close examination of most words reveals that they have many different senses and the rules which combine them into sentence meanings will frequently yield several possibilities for interpretation. Usually we resolve potential ambiguity unconsciously.

(Ladusaw 2006)

Miscommunication can be caused by linguistic ambiguity. Linguistic ambiguity occurs when a text is constructed in such a way that there are different underlying meanings or interpretations. The following example illustrates double meaning due to linguistic ambiguity.

Example 1: Visiting doctors can be a nuisance.

There are two underlying structures:

- a) The noun 'doctors' is the subject of the verb 'visit' and the missing object of the verb is 'the patients'
- b) The noun 'doctors' is the object of the verb 'visit' and the missing subject of the verb is 'the patients'.

Example 2: Invalid women and children should be treated differently.

This sentence is ambiguous. It has two interrelations as in (c) and (d):

- c) Invalid [women]: the adjective 'invalid' modifies only the noun 'women'.
- d) Invalid [women & children]: the adjective 'invalid' modifies both 'women' and 'children'.

To avoid miscommunication due to linguistic ambiguity, particularly in the health context, health workers need to be aware of two disambiguating strategies:

Paraphrasing: Instead of using only one expression, communicators use paraphrases to reinforce the meaning that one wants to convey. Thus to reinforce the meaning of statements (a) and (b) they should be paraphrased respectively as below:

1. Doctors may find it a nuisance if they have to visit patients at their own homes.
2. Patients may find it a nuisance if they have to visit doctors. The patients can have problems due to transport or fear of communicating with doctors.

Contextualising: Contextual clues are very important in receptive communication. When communicating with migrants or those who come from a different linguistic background, health workers need to make effective use of context to support the flow

of communication. Basically there are two categories of contextual clues:

- *Textual clue*: some expressions are ambiguous if they are placed in isolation or not clearly linked to the other items in a text. Conjunctions such as therefore, but, because, etc are useful. Linking sentences help readers and listeners to see meaning in context. Clauses in a sentence corresponding to time sequences are easy to understand.

Example:

“Your child must take the medicine before she has breakfast”

“Before your child has breakfast, she must take the medicine”.

The first sentence is easy to understand and the second sentence can be confusing.

- *Nonverbal clue*: Written and spoken language can be reinforced by non-verbal communication. Words like ‘big’ and ‘small’, for instance, are relative and can be very vague. A small bottle can be perceived as ‘small’ by the speaker but to the listener it can be a big one. It is useful to illustrate visually. For instance, a doctor explains to a patient about his murmuring heart problem. He uses a picture of a heart to illustrate the problem. Using words only will make it hard for the patient to understand if he has limited English.

Cognitive meaning and cultural meaning

Comparisons of different languages can lead one to pay attention to 'universals'—the ways in which all languages are similar, and to 'particulars'—the ways in which each individual language, or type of language, is special, even unique. Linguists and other social scientists interested in universals have formulated theories to describe and explain human language and human language behaviour in general terms as species-specific capacities of human beings.

(Slobin 2006)

There are two types of word meaning: cognitive and cultural. Dictionary definition is based on cognitive meaning, which is also known as referential meaning. The definitions indicate cognitive aspect of the word meaning:

- A dog has four legs.
- January is the first month of the year.
- The train arrived yesterday.

Cognitive meaning is very prominent in scientific genres. It is used to present factual information. Cognitive meaning should not include personal feelings and prejudice. In contrastive linguistic analysis, one can expect a high degree of correspondence of words with cognitive meaning across languages. Thus it is easy to translate a mathematical text or a scientific text from one language into another as far as there are equivalent words, particularly technical jargons.

In health terminology, one can assume that there is a high degree of correspondence between health terms among languages in terms of cognitive meaning, for examples the following terms exist in English and Vietnamese: cancer (ung thư), tuberculosis (ho lao), measles (bệnh sởi) etc. Therefore, there is no communication difficulty in health intercultural communication in this regard.

However, language is intricately embedded in its culture. It is impossible to divorce language from its cultural discourse. Apart from cognitive meaning, word meaning is culturally based. For example, the following words have different cultural interpretations in English and Vietnamese:

- old
- mental
- partner
- privacy
- police

In Vietnamese, the word family may include extended family members such as grand-parents, uncles, aunts, and grand children. Similarly the words 'old' and 'age' in one language can have different meanings in another language. To many Vietnamese 'old' can be about fifty years of age, but in other cultures it could be a good age to start life. The Linguistic Relativity Hypothesis states that language is too intricately linked to its own culture so that it is impossible to fully understand the message (or thoughts) through a different language.

Human beings do not live in the objective world alone, nor alone in the world of social activity as ordinarily understood, but are very much at the mercy of the particular language which has become the medium of expression for their society... The fact of the matter is that the "real world" is to a large extent unconsciously built on the language habits of the group... We see and hear and otherwise experience very largely as we do because the language habits of our community predispose certain choices of interpretation (p.177).

(Littlejohn 2002)

The implication for health communication is that health workers should not assume that fluent translation of written and spoke health texts from English to other languages or vice versa automatically leads to perfect understanding and interpretation. It becomes serious when patients literally translate some words from their language into English without realising its potential misinterpretation.

Euphemism

Euphemism is a polite way of saying something which is unpleasant and embarrassing. Human beings are also social and cultural beings. Different cultures require their language users to use language to show politeness and respects. Euphemism is one aspect of linguistic politeness. The opposite of euphemism is dysphemism.

According to Cumming (2003), the definitions of "euphemism" and "dysphemism" presuppose that there are three words for a thing in different registers: a polite word, a neutral word, and an impolite word. This accounts for sets like:

Dysphemism	Neutral	Euphemism
prick	penis	genitals
deaf and dumb	wrong with hearing	hearing impairment
mad and crazy	mentally sick	intellectual disability
take a shit	go to the bathroom	defecate

In the health discourse, inappropriate use of descriptive words about body parts may not cause serious communication breakdown but can cause communication embracement or miscommunication. Migrants with limited English may not be aware of the use of non-discriminatory language strongly advocated in Western countries. They may use words such as 'mad and crazy' for people with intellectual disability, 'deaf and dumb' for people with hearing impairment.

Cultural metaphors

Scientific language advocates the use of precise language in communication. However, human communication is full of metaphors. In Greek, metaphor means "carrying something across". A hospital can be described metaphorically as a home by some patients and as a prison by others. Through metaphors, one can understand the real meaning and attitudes of metaphor users. Lakoff states:

A large proportion of our most commonplace thoughts make use of an extensive, but unconscious, system of metaphorical concepts, that is, concepts from a typically concrete realm of thought that are used to comprehend another, completely different domain. Such concepts are often reflected in everyday language, but their most dramatic effect comes in ordinary reasoning. Because so much of our social and political reasoning makes use of this system of metaphorical concepts, any adequate appreciation of even the most mundane social and political thought requires an understanding of this system.

(Lakoff 1995)

Migrants coming to a new country bring with them their cultural metaphors to interpret their experiences in a new cultural discourse. From the Vietnamese perspective, teachers are not those who teach students in a school. Metaphorically, they are perceived as 'parents' whose responsibility is not confined to the intellectual development of the students. Area teacher is expected to be a moral leader, a role model, and a knowledge transmitter. Doctors are not just health care workers. They are metaphorically seen as *saviours* who should receive great respect not just by their patients but by the community in which they live. Students and patients are therefore discouraged to challenge their teachers and doctors. This is the reason why in Vietnamese, the word 'thầy' can be used to refer to teachers and doctors.

Words in health care such as sickness, death, life, healthy, disorders, treatment etc may be metaphorically perceived differently by migrants of different cultural backgrounds. Lack of metaphor awareness in intercultural communication can lead to misinterpretation and negative attitudes not just in the health domain but various other domains.

Linguistic and cultural stereotypes

Another source of miscommunication in intercultural interaction is cultural stereotyping. Klineberg (1982) argues that the term 'ethnic stereotypes' are "pictures in our heads" that we have the impression that we know what "they" are like even before we have actually met them. The existence and nature of stereotypes determines our perception and judgement of others. We tend to assign some distinctive features to people of different cultures and on this basis we form our action, thought and communication. Problems arise when we try to put everyone of a culture in the same basket and treat them according to our cultural stereotyping. Chinese people tend to be stereotyped as 'good with business, French men as 'romantic lovers', English people as 'cool and remote', and Australians as 'easy going'. The greatest danger of stereotyping is that it discourages us from discovering

for ourselves the uniqueness of each individual that we meet in a context. It provides a 'ready-made' mode of behaviour for us to use in interacting with 'foreigners'. Holms (1985, p. 25) points out the danger of social stereotyping:

Women in many societies are perceived through a haze of stereotyped expectations when they speak. Whatever women say, or don't say, can be used against them as evidence of their deficiencies. This is true not only in the popular imagination but also in the halls of academia.

Stereotyping is simply another word for overgeneralisation. The difference is that stereotyping carries with it an ideological position. Characteristics of the group are not only overgeneralised to apply to each member of the group, but they are also taken to have some exaggerated negative or positive value. These values are then taken as arguments to support social or political relationships in regard to members of that group (Scollon 1995). There are many potential sources of cultural stereotyping and among them language reflects cultural stereotyping very deeply. Our language contains a variety of expressions which suggest the presence of specific psychological traits in particular ethnic groups. In English, we find such ethnic stereotypes as 'Dutch treat', 'Chinese puzzle', 'Jew him down', 'to take French leave' (Klineberg 1982). Vietnamese has 'phớt tỉnh Ảng Lê' (cool like an English person), 'ăn cơm Tàu, ở nhà Tây, lấy vợ Nhật' (eating Chinese food, leaving in a French house, marrying a Japanese wife). In language, jokes and anecdotes also reflect cultural stereotyping and they are abundant in many cultures. It is important to distinguish common custom and traditional values each culture has from cultural stereotyping. For instance, in Vietnamese culture obedience and respect for teachers and older members in a family are valued as Confucianism has permeated Vietnamese culture for centuries. This is cultural awareness, not stereotyping. Cultural awareness is therefore essential in intercultural interaction

In area of health care, stereotyping is not an uncommon communicative behaviour among people of different cultural backgrounds. Some migrants may stereotype a nurse as female. Hospitals are stereotyped as a place of people with illness. Thus people go to hospitals when they are sick. Very few will go to hospitals for normal check-up. Similarly psychiatrists are stereotyped as specialists for mentally ill patients. People are reluctant to see a psychiatrist for fear of being labelled as 'mentally sick'.

Pragmatic intercultural communication

The study of language in its social context tells us quite a bit about how we organize our social relationships within a particular community. Addressing a person as 'Mrs.', 'Ms.', or by a first name is not really about simple vocabulary choice but about the relationship and social position of the speaker and addressee. Similarly, the use of sentence alternatives such as 'pass the salt', 'would you mind passing the salt', or 'I think this food could use a little salt' is not a matter of simple sentence structure; the choice involves cultural values and norms of politeness, deference, and status.

(Wolfram 2006)

Conversation analysis provides useful ways of understand how a conversation works in a social context and how it varies among cultures. It is a complex language activity which is based on conversational principles or maxims. A conversation has a framework involving patterns of turn-taking, initiating and terminating verbal moves. For example:

Doctor: Good morning Tam

Patient: Good morning Dr. Smith

Doctor: Please sit down.
Patient: Thank you, Doctor
Doctor: What I can do for you today?
Patient: Doctor, I need antibiotics for my sore throat.
Doctor: Let me have a look and see what I can do for you.
Doctor: I don't think you need antibiotics.
Patient: Doctor, it helps me to get well quickly.

This short sample of conversation or doctor-patient interaction reveals a number of interesting cultural issues about pragmatic intercultural communication.

- *Addressing in a health context:* Addressing reflects the role and status of the participants. The doctor addresses the patient by the first name as he knows Tam well and wants to give Tam a friendly informal atmosphere. Both of them are approximately of the same age; whereas Tam still addresses the doctor by his title, which is common in a doctor-patient genre. Vietnamese migrants tend to use Mr. and Mrs. in addressing others in a formal context such as "I am Mr. Tam" or "I am Mrs. Thu". Words such as surname, family name, first name, last name and Christian names can be confusing to some migrants. In Vietnamese and Chinese, first name is the family name. Married women in Vietnam do not officially use the surname of their husband. They keep their maiden names.
- *Health professional roles:* In Vietnam, an antibiotic is not a prescribed drug. It can be bought at any chemist shop and there are no specific instructions on how it should be used. It indicates the different ways in which health workers' roles are perceived in different cultures. In Vietnam, chemists can play a role of 'a daily or family doctor or nurse'. People go to the chemist to ask for advice on how to treat their sickness. Problems arise in the Australian context due to migrants' different perception, expectation and attitudes towards health workers.

The nature of interaction between patients and health workers is culturally governed. It is important to know about the norms and values that underlie interaction in an intercultural discourse. Lie supports this view as he points out:

What do we know about the norms and values that govern physician patient or nurse patient interactions in other countries? The answer is that we know surprisingly little, and much of what we appear to know is based on studies of questionable relevance.

(Lie 1995)

Migrants and youths

We face an imperative to train our future doctors and other health professionals to provide culturally relevant health care (not just to those who are immigrants). We are obligated to include in their life long learning a foundation of cultural awareness, knowledge, understanding, sensitivity and competence, to equip them to keep abreast of the changes that inevitably will continue in Australia's ethnic and cultural mix, and to tune their clinical 'best practice' according to this moving scene.

(Eisenbruch & Dowton 2000).

According to Margareth and Irai (2006), the ability of migrants to access health care

services in developed countries varies widely. It depends on their immigration status, country of origin, cultural and traditional beliefs, and ability to navigate services. The common factors for migrants not seeking health services are:

- *Barriers to access and services use:* Language and cultural barriers often mean that ethnic immigrants are not clear about the health care services, including health information, that are available to them. They are also not clear about their benefits. Therefore, it influences their ability to access the services and information.
- *Lack of information about certain health services available:* It is a result of language and cultural barriers. This causes relative underused of preventive health screening and under-diagnosis and treatment of health problems.
- *Use of herbalists and other alternative health providers for their own and their family members' health issues.*
- *Lack of culturally sensitive or acceptable health services available for ethnic communities:* Some immigrants express discomfort discussing traditional practices with health care providers or asking for additional information when they do not understand the health and medical information provided. Therefore, it is important to be aware of and sensitive to the intended audience's age, gender, ethnicity, and religious and cultural beliefs in planning intervention approaches aiming to create educational and self-care health materials.

Language, communication and culture underlie all the above factors. This is one of the main reasons why migrants tend to live in the suburbs where these factors facilitate their well-being, particularly healthcare. For instance in Melbourne, suburbs such as Footscray, Springvale, Richmond, and St. Alban are considered as the second home of many Vietnamese migrants. These communities are valuable as a significant source of social capital in terms of education, entertainment, childrearing, and health care.

An important issue for many migrants is palliative care. According to the World Health Organisation (2006), palliative care improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement. Spiritual and psychological support is emphasised here. In many cultures where family bond is very strong, it is the responsibility of family members to look after their elders and members with a life-limiting illness.

The concepts of palliative care, being a relatively new medical sub-specialty, remain open to new influences. Culture should be considered a significant influence, which in turn will positively impact the true quality of living and dying. Additionally, the exclusion of culture can in itself, become a barrier to the utilization of palliative care.

(Janelle & Celeste Mulry 2006)

In a new cultural context, it is very demanding, if not impossible, for migrants to keep this traditional practice of care for family members with a life-limiting illness. In addition to the physical and psychological burdens, migrants also have to confront the intercultural communication conflict between the new cultural discourse and the home discourse. One critical issue is the communication with the patients about their life-limiting illness. In the West, the concepts of human right and self-determination are essential in health care. Patients are entitled to know the condition of their health. Concealment of information from patients is a deception; whereas many non-Western cultures adopt a conspiracy of silence as family members and health workers prefer

to conceal the diagnosis and prognosis of illness from seriously ill patients, to protect them from painful information which can prolong their suffering and destroy their hope.

In applying Western principles to another culture, the caregiver should first consider the individual's interpretation of autonomy. In the West, this concept assumes the moral value of independence, self-determination, privacy and competence-an assumption that under-girds virtually all health-care processes. Both biomedicine and bioethics assume that the person experiencing the illness is the best person to make health-care decisions. However, many non-Western cultures perceive the family or community as vital in receiving and disclosing information necessary to decision making and to the organization of patient care.

(Bowman 1997)

An important issue about culture and health is the emergence of youth as a discourse. Young children and adolescents constitute a new category of membership in a society. Their beliefs, values, life styles, and behaviours can be greatly different from their older generation. The generation gap can create a communication gap between children and adults. Thus, some parents may not have great influence on educating and guiding their children in dealing with a rapidly changing world which is full of health-related problems such as HIV, drug, smoking, alcohol, depression and obesity. Without the influence and security of their home, young people can become an easy target of abuse, particularly those who cannot adjust to a new language and culture or those who have gone through traumatic experiences in their home countries.

However, on the positive side, youths can benefit from their own cultures which have strong views against drug, smoking, premarital sex etc. Youths with such cultural backgrounds may not be easily influenced by their peers to be involved in health risk behaviours and activities.

Conclusion

Traditionally the concept of health tended to be confined to physical illness and its intervention and treatment. Now this concept has been broadened to cover the wellbeing of people. As people are cultural beings, their views and attitudes towards health are deeply influenced by their cultural backgrounds. Health professionals in Australia do not work in a monoculture society.

This paper has examined various aspects of communication including linguistic nature of communication, interpersonal communication and intercultural communication, particularly in the context of health care. It gives some insights into the essential role that communication and culture play in health care. In a multicultural society, people with different linguistic and cultural backgrounds may perceive health concepts and issues differently and this can lead to various problems such as miscommunication, inappropriate behaviours, mistrust, and failure to make full use of health care. From the perspective of health care providers and policy makers, intercultural awareness should be valued and translated into practice to ensure that migrants are not excluded from participating meaningfully in health care and they are not at the mercy of the dominant culture; otherwise, health care can become a discriminatory discourse.

References

Bowman, K 1997, *Bioethics and Cultural Pluralism*, viewed 10 October 2006, <http://www.humanehealthcare.com/Article.asp?art_id=776>.

- Carolyn, P 2001, 'The impact of culture on rural women's descriptions of health', *Journal of Multicultural Nursing & Health*, vol. 7, no. 1, p. 50.
- Cumming, S 2003, *Language and Power*, viewed 15 October 2006, <<http://www.linguistics.ucsb.edu/faculty/cumming/ling50/euphemism+dysphemism.htm>>.
- Eisenbruch, M & Downton, B 2000, *A proposed multicultural health program at University of New South Wales: Productive diversity for the health of the people of Australia*, Department of Immigration and Multicultural Affairs.
- Holmes, J 1985, 'Sex differences and miscommunication: some data from New Zealand', in J Bride (ed.), *Cross-Cultural Encounters - Communication and Mis-communication*, River Seine Publications, Melbourne.
- Janelle, T & Celeste Mulry, B 2006, 'Palliative Care and Culture: An Optimistic View', *Journal of Multicultural Nursing & Health*, vol. 12, no. 2, p. 28.
- Klineberg, O 1982, 'Contact between ethnic groups: a historical perspective of some aspects of theory and research', in Bochner (ed.), *Cultures in Contact*, Pergamon Press, Oxford.
- Kreuter, MW & McClure, SM 2004, 'The role of culture in health communication', *Annual Review of Public Health*, vol. 25, pp. 439-455.
- Ladusaw, W 2006, *Meaning*, viewed 16 October 2006, <<http://www.lsadc.org/info/ling-fields-mean.cfm>>.
- Lakoff, G 1995, *Metaphor, morality and politics*, viewed 18 October 2006, <<http://www.wwcd.org/issues/Lakoff.html>>.
- Lasswell, H 1948, 'The structure and function of communication in society', in L Bryson (ed.), *The communication of Ideas*, Harper, New York., pp. 32-51.
- Lie, RK 1995, *Cross-cultural medical ethics*, viewed 24 October 2006, <<http://www.hf.uib.no/i/Filosofisk/ethica/pittsburgh.html>>.
- Littlejohn, S 2002, *Theories of Human Communication*, Wadsworth, New Mexico.
- Margareth, SZ & Iraj, MP 2006, 'Health Literacy Within the Reality of Immigrants' Culture and Language', *Canadian Journal of Public Health*, vol. 97, p. S26.
- McGuire, W 1989, 'Theoretical foundations of campaigns', in R Rice & C Atkin (eds), *Public Communication Campaigns*, Sage Newbury Park, CA, pp. 43-65.
- Scollon, R 1995, *Intercultural Communication*, Blackwell, Oxford.
- Slobin, D 2006, *Language and thought*, viewed 16 October 2006, <<http://www.lsadc.org/info/ling-fields-thought.cfm>>.
- University of Washington 1998, *Issues and Diverse Beliefs with an Emphasis in Paediatrics*, viewed 18 October 2006, <<http://depts.washington.edu/bioethx/topics/cross.html>>.
- Wolfram, W 2006, *Sociolinguistics* viewed 10 October 2006, <<http://www.lsadc.org/info/ling-fields-socio.cfm>>.
- World Health Organisation (WHO) 2006, *Palliative care*, viewed 18 October 2006, <<http://www.who.int/cancer/palliative/en/>>.